## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/08/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANS CARE & REHAB CENTER-CASTLETON  STREET ADDRESS, CITY, STATE, ZIP CODE 5226 8 28/30 ST  NOINANPOULS, IN 46250  SUPPLIES TAG  SEMBLARY STATEMENT OF DEFICIENCIES THE SEARCH STATEMENT OF DEFICIENCIES TAG  FOOD  INITIAL COMMENTS  This visit was for the Investigation of Complaint IND0085500 unsubstantiated due to lack of evidence.  Survey dates: February 3 & 4, 2011  Facility number: 100267130  Survey team: Rita Mullen, RN, TC Janet Stanton, RN Michelle Hosteter  Census bed type: SNF/RF: 145 Total: 145  Census payor type: Medicare: 31 Medicaci: 95 Other: 19 Total: 145  Sample: 3  Kindred Trans Care & Rehab Center - Castleton was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Outpaint Involves 5500.  Quality review completed 2/7/11 by Jennie  Bartelt, RN.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
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Summary Statement of Deficiencies   Deficiency Must Statement of Deficiency Must Stat	155272			B. WING			02/04/2011	
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  This visit was for the Investigation of Complaint IN00085500.  Complaint IN00085500 unsubstantiated due to lack of evidence.  Survey dates: February 3 & 4, 2011  Facility number: 000172  Provider number: 155272  AlM number: 100267130  Survey team: Rita Mullen, RN, TC  Janet Stanton, RN  Michelle Hosteter  Census bed type: SNF/NF: 145  Total: 145  Census payor type: Medicare: 31  Medicadi: 95  Other: 19  Total: 145  Sample: 3  Kindred Trans Care & Rehab Center - Castleton was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Completed 2/7/11 by Jennie Bartelt, RN.					5226 E 82ND ST			
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Bartelt, RN.				TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR

TLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.